A Report of Early Professional Experiences

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A REPORT OF EARLY PROFESSIONAL EXPERIENCES

by

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A project report submitted to the Faculty of the School of Graduate Studies in partial fulfillment of the Degree of Specialist in Education

Western Michigan University
Kalamazoo, Michigan
December 1966
ACKNOWLEDGEMENTS

The author wishes to express her sincere appreciation to the personnel of the Kalamazoo Valley Intermediate School District, Kalamazoo, Michigan; Kalamazoo State Hospital, Kalamazoo, Michigan; John F. Kennedy Center, Kalamazoo, Michigan; and Twin Cities Child Guidance Clinic, Saint Joseph, Michigan. The training and advice provided by these individuals, too numerous to identify here, have formed the basis of the program discussed in this paper.

Joy Rogers
MASTER'S THESIS M-1207

ROGERS, Joy
A REPORT OF EARLY PROFESSIONAL EXPERIENCES.

Western Michigan University, Ed.S., 1967
Education, psychology

University Microfilms, Inc., Ann Arbor, Michigan
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RATIONALE FOR THE ORGANIZATION
OF INTERNSHIP EXPERIENCES

Since textbook descriptions of professional opportunities available in the areas of child and educational psychology provide a limited picture of the conditions involved, it was the author's purpose to participate in a series of early professional experiences that sampled many aspects of child and educational psychology. For this reason the author selected internship positions in a community child guidance clinic, an intermediate school district, and a first paid position at an in-patient treatment center for children at a large state hospital. Thus it has been possible for the author to become reasonably familiar with each of the above-mentioned types of institutions.

The author's first internship was taken during the summer of 1965 at the Twin Cities Child Guidance Clinic in Saint Joseph, Michigan. This is a center for the diagnostic evaluation and outpatient treatment of children with emotional disturbances and other behavioral disorders. Children are referred to this clinic from sources such as schools, doctors, other community agencies, and directly by their parents. No
matter what agency refers the child, the written permis-
mission of the parent or guardian must be obtained be-
fore the child can be accepted as a patient. The sec-
retary receiving this initial contact with the parent
obtains basic information such as the child's address,
age, grade in school, and the general nature of his
problem. Since the clinic typically has a waiting list
of such referrals, the child may wait several weeks be-
fore the next clinic contact which will be a screening
interview. In the interim, the child's parents are
given a report form for medical data about the child
and are asked to have their physician provide that in-
formation. The child does not attend the screening
interview. Instead, one or both of his parents meet
with one of the staff social workers. It is the social
worker's task to determine the nature, duration, and
severity of the problem as seen by the parents. The
social worker may also choose to give the parents some
advice as to how to deal with the child until the
clinic can offer more extensive contact. On the basis
of this interview, the social worker will determine
whether to offer clinic services for the case or to
advise the parents and discontinue service at this point.

If clinic services are offered, an appointment will
be made for the parents to meet again with the social
worker. At this time a case history is taken and any
matters of concern about the child that have arisen since the last interview are discussed. While the parents are meeting with the social worker for the case history interview, the child is generally seen by a psychologist.

The psychologist usually has a short interview with the child for the purpose of establishing rapport and assessing the way the child sees his own problems. After this, the psychologist will, in most cases, administer one or more psychological tests. A typical test battery would include the Wechsler Intelligence Scale for Children, the Bender Visual Motor Gestalt Test, and the House-Tree-Person Test. Variations from this pattern sometimes include the substitution of another individual intelligence test for the Wechsler Intelligence Scale for Children or the Wide Range Achievement Test for one of the other two tests in the battery. If the psychologist fails to obtain enough recommendations for the child, he may schedule one or more additional sessions with the child to complete his diagnosis. At such times he can give any projective or nonprojective tests that he believes useful, interview the child, or take him to a play area to observe his behavior.

If either the psychologist or the social worker feels that an additional professional opinion about the child is needed, an appointment is arranged with one of
the psychiatrists employed by the clinic on a part-time basis. The psychiatrist may choose to see either the child, the parents, or both.

After these data have been collected, a "staffing" is held. All the professional staff members involved attend this meeting and report their findings. It is clinic policy that either the clinic director or one of the psychiatrists must be present at each staffing. The purpose of the staffing is to determine the disposition of the case. A case may be discharged at this point. If this is done, arrangements are made to report the clinic's findings to the parents as well as to social agencies such as the school. Due to the great demand for clinic services, most cases are handled in this way. Other alternatives in planning treatment for the child include referral to other agencies. These will be discussed more fully later in this paper. If the psychiatrist believes that medication would be helpful for the child, drugs can be prescribed. In that case, the child's name remains in the clinic's active files although he is seen only infrequently to determine what effects the medication has on his behavior. Active clinic treatment is prescribed for a few children. Each child offered treatment is assigned to a psychologist or psychiatrist for this treatment. Each therapist then determines whether he will see the child alone, see the child and
parents separately, see the child and parents together, or see the parents alone. When therapy is terminated, another staffing is required to close the case.

Like the Twin Cities Child Guidance Clinic, the special education services of the Kalamazoo Valley Intermediate School District are for children with emotional disturbances and other behavioral disorders. The author's second internship was taken with this agency in the Spring of 1966. By law, the school diagnostician is required to test only those children thought to be mental retardates. In practice, this is not the case. Many children with learning problems are seen by the diagnostician. His task, then, is one of selecting those eligible for placement in programs for the mentally handicapped and making whatever recommendations may be possible for the other children he has seen. The vast majority of children seen by the school diagnostician are not eligible for programs for the mentally handicapped.

The children to be evaluated for placement in programs for the mentally handicapped are first referred by the classroom teacher. She is asked to specify whether she suspects the child's problem to be one of emotional difficulty, learning difficulty,
suspected retardation, or a number of other possibilities. Her request for the services of a diagnostician must be approved by the principal of the building in which her classroom is located. After such a request has been approved and forwarded to the intermediate school district office, a diagnostician visits the school for the purpose of evaluating the child.

The approaches to testing used by diagnosticians tend to be quite individualized. Usually, however, the diagnostician will begin by reviewing the problem with the teacher who made the referral. Then the diagnostician will frequently observe the child's behavior in the classroom. The diagnostician may also examine the child's school records. These actions are generally done to ascertain the nature of the problem the child presents before he is tested. At this point, the diagnostician will take the child to an area of the school building not then in use for testing. There he is given an individual intelligence test and an achievement test. The most commonly used intelligence test is the Wechsler Intelligence Scale for Children although the Stanford Binet Intelligence Scale: Form L-M is used with children who are six years old or younger or who have recently been given.
the Wechsler Intelligence Scale for Children. The Wide Range Achievement Test is generally administered. Additional non-projective tests may be given at the discretion of the diagnostician. Those commonly administered the Peabody Picture Vocabulary Test, the Bender Visual Motor Gestalt Test, and figure drawings. On occasion, the diagnostician may administer an individual reading test or the Illinois Test of Psycho-linguistic Abilities.

The diagnostician writes a report of his findings which becomes a part of the child's permanent school records. If mental retardation has been suspected by either the referring teacher or the diagnostician, the child's name is brought before a screening committee. This committee is usually composed of administrators, special education teachers and classroom teachers. State law requires that a diagnostician be present whenever such a committee meets. The purpose of such a committee is to determine which children shall be offered special education services. Factors such as the child's intelligence, achievement levels, chronological age, and overall social development are taken into consideration. If this committee believes special class placement is appropriate for the child, such a recommendation is made. If the child's parents
or guardians agree to the placement, he enters a special education class. If mental retardation is not suspected, the child's name is not brought before a screening committee and a report of the test findings is simply placed with his school records.

The diagnostician is also legally required to retest all children in programs for the mentally handicapped at least once every two years. The screening committee then discusses the child again to determine if special education placement is still in his best interests.

The children's services of Kalamazoo State Hospital reach children whose disturbances vary in degree rather than in kind from those served by the Twin Cities Child Guidance Clinic or the Kalamazoo Valley Intermediate School District. The author has been employed as a clinical psychologist within the children's services of the Kalamazoo State Hospital since June, 1966. Children at the hospital include all persons admitted prior to their seventeenth birthday. Individuals younger than seven are rarely admitted to the hospital. Children are retained on children's services until they are discharged from the hospital or until it is determined that they would benefit more from the services for adults.
Many other aspects of the programs for children at the Kalamazoo State Hospital make them markedly different from the two agencies previously described. First of all, the hospital assumes the legal rights usually retained by a child's parents. The hospital also gives inpatient care to virtually all its children, so the hospital directly influences a much greater share of a child's life than do the other agencies described. The children at Kalamazoo State Hospital are frequently persons who have already been seen for diagnosis or treatment by the special education division of an intermediate school district or a child guidance clinic.

The psychologist's role in the hospital's programs for children has much in common with a psychologist's role in either of the two organizations previously described. The main body of children referred for testing are those recently admitted to the hospital. Children who have been in the hospital for some time are also occasionally referred for testing. A doctor or any member of the staff who believes that some type of psychological testing is needed can initiate such a request for testing. The psychologist's report becomes a part of the child's case records. The results are used by such personnel as psychiatrists.
teachers, and social workers as they need them in
their work with the child. Periodic staff conferences
are held about each of the children and the results
of psychological testing may be presented then.

The task of testing children at the Kalamazoo
State Hospital is, in many respects, more difficult
than in a school system or a child guidance clinic.
The greatest source of difficulty is that children
admitted to the State Hospital have often already been
seen and tested at numerous agencies. Therefore, the
use of many of the more accepted instruments is
contraindicated since results from them would be
contaminated by the effects of practice. Since this
is often the case with the most highly respected test-
ing instruments, the hospital psychologist must often
use a test of lesser quality. The child's behavior
is often a greater problem to the hospital psychologist
than to psychologists in out-patient agencies since
it might be assumed that only the children whose be-
behavior was most disturbed would be likely to be ad-
mitted to a State Hospital. The behavior of some
child patients is so bizarre that psychological tests
cannot be administered to them. Other children are
either so retarded or so emotionally disturbed that
even their stronger behaviors fall below the minimum
scorable levels of psychological tests.

The hospital psychologist often sees children on an individual basis for therapy. This is never done by the school diagnostician and is done much more infrequently by the child guidance clinic psychologist. The frequency of therapy interviews and the type of therapy conducted is left largely to the discretion of the psychologist.

Since it was the author's purpose to become familiar with a diversity of agencies serving exceptional children, visits to some of these agencies were informative. The internship at Kalamazoo Valley Intermediate School District provided the opportunity to make these visits.

**Custer Job Corps Center**

The Job Corps is part of the federal antipoverty program. Federal funds are used to staff and maintain the centers as well as to pay the trainees. The Job Corps Center at Fort Custer, Michigan is a training center designed to teach job skills to out-of-school youths between the ages of sixteen and twenty-one. Only male Job Corps trainees are sent to Fort Custer. Each Job Corps center is certified to offer certain kinds of training programs. Fort Custer has several
including automobile mechanics and the operation of heavy construction equipment. In so far as work related to maintaining the Job Corps facility is related to their job training area, the Job Corps Center may use their trainees for such a purpose. For example, the trainees have repaired automobiles for use by the Job Corps and have built a road to a lake on another part of the grounds. Since this particular Job Corps Center does not have specific training programs in fire-fighting or cooking, the firemen and cooks needed at the Job Corps Center are not trainees but employees.

Each trainee's daily program consists of a half day academic program in remedial reading, mathematics, and citizenship. The remaining half day is spent in training in a specific job skill area. Each job skill for which the Job Corps has a training program is organized into modules. For example, the first module in the automobile mechanics program requires that the boy make his own metal tools. As soon as he has completed this task to the satisfaction of his teacher, he begins to perform the tasks of the second module. He then progresses through tasks such as diagnosing what is wrong with an automobile engine and overhauling it himself. When he completes the last module
satisfactorily, he is eligible for graduation from the program. The Job Corps Center staff indicates that the work modules are selected so that the trainees will achieve a sense of pride in his work and so the skills will build upon each other.

The Job Corps trainees live in remodelled army barracks under the guidance of a Group Life Supervisor. They are expected to conform to a minimum of rules established by the trainees themselves. The rules are of the nature of maintaining the general health of the trainees as well as some social decorum.

**Custer State Home.**

The State Home at Fort Custer, Michigan was opened in 1956 as a temporary facility for the care of mentally retarded individuals in order to reduce the waiting lists for admission to the established state homes and training schools. Since the Department of Mental Health has not been able to complete facilities for the retarded rapidly enough, Fort Custer State Home remains in existence. This facility houses its 1300 patients in structures used formerly by the Fort Custer Station Hospital.

Fort Custer State Home residents vary in age from infancy to eighty years. About a third of
these patients require complete or partial bed care. The patients at Fort Custer State Home have intelligence quotients of about 70 or below. They are grouped according to age, sex, physical mobility, and severity of retardation. Many of the mildly retarded patients work off the grounds and return to the State Home each evening. Other patients may do food service or custodial work on the grounds of the State Home.

Although Fort Custer State Home was not designated as a training facility, programs are being initiated for patients identified as trainable and educable. Vocational Rehabilitation services are also being obtained for some patients. Aside from this training, care at Fort Custer State Home is largely custodial.

**Kalamazoo Child Guidance Clinic**

This clinic is an out-patient treatment center serving several counties. Since its operation is similar to that of the Twin Cities Child Guidance Clinic, it will not be discussed at greater length in this paper.

One unusual procedure used by the Kalamazoo Child Guidance Clinic is the scheduling of interviews. One child is scheduled for diagnosis each
day. During the morning various members of the staff interview the parents and the child. Their information is compiled and a staff conference is held. Early in the afternoon, a social worker reports the clinic findings to the parent. The staff spends the remainder of the afternoon in conferences and giving therapy.

The Kalamazoo Child Guidance Clinic also operates the Hull-Paulson Center—a day care facility for emotionally disturbed children located on the grounds of the Lakeside Children's Home in Kalamazoo. At the time the Hull-Paulson Center was visited by the author, it was staffed by a social worker who also served as director and by a teacher of the emotionally disturbed. Two children were enrolled in the program. Plans for expansion of the program were indicated. The Hull-Paulson Center is intended to serve children who have been excluded from public schools by reason of their emotional disturbances.

Kalamazoo County Juvenile Home

This facility has been established for the temporary care of children who, either through being neglected or behaving in an antisocial manner, have come to the attention of the court as being
in need of temporary or permanent removal from their homes. The Juvenile Home is a temporary residence for these children since efforts are made to return them to their homes, place them in foster homes, or have them admitted to a long term treatment facility as promptly as possible.

Most of the children at the Juvenile Home receive residential care. However, there are usually some children who receive only day care and return to their homes at night. The Juvenile Home provides a school for the children detained there. The program includes highly individualized instruction in the academic subjects, industrial arts and physical education for all children, and home economics for the girls. Recreation is also provided to the ward groups. Children whose behavior becomes disruptive are segregated in isolation rooms until they become controllable.

**Lakeside Children's Home**

The Lakeside Children's Home is a residence for children and adolescents in need of a group living situation. They are frequently children who have not adjusted adequately to foster home placements.

The children residing at Lakeside attend
elementary and secondary schools in the community. Lakeside Children's Home has spacious grounds, facilities for recreation, and lake frontage for swimming and boating. Cottage style living areas are designed to look and operate as much like family homes as possible.

Sofen Clinic

Dr. Harry Sofen, a Kalamazoo optometrist, operates a clinic for children he considers to be perceptually handicapped. Since the clinic is privately operated, parents pay the full cost of their children's treatment. The children served by the clinic are usually seen first when they are brought in for fitting for glasses. These children are also often poor readers.

Dr. Sofen believes that good vision is a product of effective muscular control and that this control can be learned. Therefore he does not prescribe corrective lenses for the children he plans to treat until after they have completed the treatment program. Eye exercises are only a small part of this program. Many gross and fine motor coordination exercises are included. Frequently exercises of more than one type are performed at
a time. For example, the child may be expected to identify alphabet letters while walking on a balance beam or to trace forms from a template while standing on a teeter board. The child's parents are often trained to help their children with the exercises. This makes the treatment program more economical for the child's family.

Dr. Sofen believes that normal development includes many of the experiences his program provides. That is, children ordinarily crawl through drain tiles, balance on fence rails, and jump from railroad tie to railroad tie. These experiences are, according to Dr. Sofen, essential for the child in learning about the dimensions of his body and how it can be used. His program, then, teaches these things to children who presumably do not know them.

Special Education Programs

The author has visited several classrooms for educable mentally handicapped children in the Kalamazoo Valley Intermediate School District. These classrooms tended to accommodate no more than the state reimbursable maximum of fifteen children. Such classrooms were located in buildings which
mainly housed regular school programs. The district program is organized into primary, intermediate, junior high, and senior high school classes for educable mentally retarded children.

The author visited one of the two perceptual development classrooms in the Kalamazoo Valley Intermediate School District. There were six children in the class and all worked at individual study carrels. They spent much of their time assembling jigsaw puzzles, copying or tracing designs, and doing Frostig drawing exercises. The program included many of the same exercises as were observed at Dr. Sofen's Clinic, but fewer gross motor exercises were included. There seemed to be some attempt to provide the apparatus used at the Sofen Clinic, but this appeared to be limited by financial as well as space restrictions. While a balance board was used in the classroom, the Marsden Ball apparatus employed extensively by Dr. Sofen was not present here. No uniform program for the referral or selection of students was observed.

The John F. Kennedy Center is a separate physical plant provided for trainable mentally retarded children. The author conducted a study
of several months duration on the verbal develop-
ment of children as part of her course work at
Western Michigan University as well as visiting the
Center several times to observe children as part of
her internship. Familiarity with most of the child-
en and teachers was achieved. The John F. Kennedy
Center program is organized on a modified depart-
mental basis. Each child has a "homeroom" for such
activities as snacks, show and tell period, and
communications skills. He then enters a special-
ized program for activities such as creative rhythms,
physical education, crafts, home economics, and
industrial arts. The homeroom groupings are deter-
mined on the basis of overall developmental level
while specific class groupings are made on the basis
of the development of skills in areas appropriate
to the subject matter of the class. Thus it is
entirely possible for a sixteen year old to be in a
homeroom with the oldest children, but in a creative
rhythms class with the youngest. The school day
begins at 9:00 a.m. and ends at 1:30 p.m. at the
Kennedy Center. Lunch is considered to be an in-
tegral part of the program there as the children are
trained in table manners and health habits. Child-
ren admitted to the program at Kennedy Center must
be toilet trained and be of such limited intelligence that they are not eligible for placement in educable programs. Two classrooms at the Kennedy Center are used by a parent group, the Kalamazoo Association for Retarded Children. The children in these classrooms either do not meet the minimum qualifications for the program or have not yet been admitted to it. These classrooms are not included in Kennedy Center's departmentalization.

The author also visited the Harold Upjohn School. Programs are provided here for children who are orthopedically handicapped, speech handicapped, blind, partially sighted, and deaf or hard of hearing. The school is equipped with a hydrotherapy pool, cot room for an actual rest period, and many kinds of special apparatus needed for treating special handicaps and teaching those afflicted with them.

**Youth Opportunities Unlimited**

Youth Opportunities Unlimited, commonly known as YO.U., is a privately supported modified sheltered workshop program. It is designed to provide job training, job placement, and guidance to out of school youth between the ages of sixteen and twenty-one.
The Y.O.U. center has much of the appearance of an industrial plant. In these work areas the participants complete tasks given the workshop on consignment from local industries. They are paid on a piecework basis. Each participant is also required to attend classes where such things as consumer mathematics, remedial reading, and how to apply for a job are taught. At the same time the participants are urged to complete a high school education. Public recognition is given the participant for regular and prompt attendance as well as good citizenship.
INTERNSHIP ACTIVITIES

The author's first internship was taken at the Twin Cities Child Guidance Clinic in the summer of 1965.

Her responsibilities there consisted primarily of testing. Usually the author administered about four test batteries each week. These batteries included either the Wechsler Intelligence Scale for Children or the Wechsler Adult Intelligence Scale, depending on the age of the child being tested. The Bender Visual Motor Gestalt Test and the House Tree Person Test were frequently administered also. The author had access to a playroom where materials selected to provide diagnostic information about the child were available. Information gained from the child in an interview situation was also considered a part of the total testing process.

The procedure for testing a child most frequently began by meeting the child in the lobby while his parent or parents were still waiting there. Shortly thereafter, the parent would meet with the social worker. On occasion the child would become concerned about the whereabouts of the parent or vice versa.
In that event one would be brought to visit the other to reassure them of each others well being.

Testing was always prefaced by a short interview—primarily as a "rapport-getting" device. This interview was often as informative as any of the test results. The most useful single question used by the author seemed to be, "Why have you and your parents come to the clinic?" This question, which was often answered at variance with the reason stated in the case records, revealed such things as the child's general alertness, his awareness of reality, and the truthfulness with which his parents dealt with him.

Tests would then be administered. While no attempts were made to rush the child, the author did try to limit the length of the testing session to one and one half hours. The purpose of this was to avoid fatiguing the child unduly and to maintain reasonable rapport. Children could be returned for a second testing session if the tests became too lengthy. However, the author never found a need to do this. After testing, the child would be returned to his parents in the waiting room.

The desirability of "testing blind," that is, administering and interpreting tests without having any prior information about a child, is a commonly
discussed issue among psychometricians. The author tried testing both with and without previous information. She generally believed that having the information about the child before testing was superior to not having such information. The primary reason was that often talking with the child and testing the child left the author with no real idea as to why the child had been referred. Since the recommendations made as well as the selection of tests to be administered were largely dependent on the reason for referral, the child's stamina, and other factors often available in the case records, "blind testing" proved to be unsatisfactory.

The author also attended staff conferences. At these meetings she was expected to contribute the results of her psychological testing and to enter into the discussion on the clinic's planning for the child.

As a part of the supervision of the author's internship, the author had a discussion period with the clinic director for each test battery she administered. If a discussion of the case did not consume all the available time, the remainder was used for discussions of testing and therapy techniques.

The author's second internship was taken at the

Her duties there consisted of testing children referred by their teachers. Selection of referrals to be answered by the author was made on the basis of geographic convenience. The school district was roughly sectioned into thirds so that each of the three persons testing for the district worked in a specific area. The author generally tested from four to five children each week. If more than one referral came from the same school, then these children would be tested on the same day if possible. Otherwise referrals were answered in negative order of recency.

When the author arrived at a school building where she was to test a child, she first contacted the principal to inform him that she was in the building. If he was not available, she would leave a specially prepared form for him indicating who she was testing and whether she would like to meet with the principal afterward. The author would then locate both the child's classroom and the most suitable area available for testing. Often the most suitable area was only marginally suited for testing. For example, in one school, the author had to test in a classroom next to the music room and often shout
test questions over the songs from next door. In another school the author tested in the library while the librarian busied herself by shelving books on a nearby bookcase and staring at the child. In a third situation, the author tested in an unused speech therapy room while a queue of mothers and small children clamored outside the door during a pre-kindergarten roundup. Even when such situations did not arise, the children were often fearful of missing recess or physical education so that their sustained efforts were difficult to maintain. The author would write a report of her test findings which would be provided to the school from which the child was referred. If the child's name were brought before a screening committee for possible inclusion in the program for the educably mentally handicapped, the author was expected to attend.

Many visits to community social agencies were made during this internship. They have been enumerated elsewhere in this paper.

Supervision during this internship involved having the district's diagnostician read and approve the author's work.

The author's first professional employment was
with the children's services of the Kalamazoo State Hospital beginning in June, 1966.

The primary element of children's services at the hospital is the Children's Unit, a school and living facility with a capacity of about ninety children. This is less than three fourths of the child population of the hospital. The others are housed in facilities primarily intended for adults. Some of these are awaiting an opening in the Children's Unit, but others show kinds of behavioral deviations which can be handled more adequately on the adult wards. Patients are classified as children if they are admitted to the hospital before they reach their seventeenth birthday. They are retained on Children's Services only so long as they seem likely to profit from a children's program.

Children who can profit from any schooling are given the opportunity to attend. The majority of children are enrolled in Tower Heights School, a group program operating in the Children's Unit. Classes are not organized in grades, but into six levels, corresponding roughly to the first ten grades of school. Tower Heights School is not accredited and cannot issue diplomas. However, transfer credit to accredited schools is accepted.
virtually without question. Older children usually finish the later grades in the Kalamazoo area public and parochial schools if hospitalization is still required. Children who have the ability to finish high school, but whose behavior prohibits their being sent off the hospital grounds to do so, are given correspondence courses.

Another, more individualized school program is provided for children with more limited academic potential or more severe behavioral aberrations. These children are also provided with individual tutors whenever possible. Some children may only have tutors and individual instruction because of their disruptiveness in groups. Finally there are some children apparently incapable of profiting from any kind of instruction and they are totally excluded from school.

The psychologist's findings serve a dual purpose at the hospital. They are first used by the doctor in his planning for the child's treatment. They are secondly used by the school personnel in establishing their expectations for the child.

The author's duties consist of testing new admissions and other referred patients, and doing therapy. The general treatment program is largely
milieu therapy and the so-called "depth" therapy procedures are discouraged. Operant techniques are often used with the more disturbed patients.

Throughout these early professional experiences, the author has experienced a focusing of her interests on the emotionally disturbed child. It has appeared to the author that a greater proportion of services are already available for children with other types of deviations. It also seems that the author's academic background has equipped her more fully for dealing with the emotionally disturbed. Therefore work in this area offers more interest to the author than work with the gifted, retarded, or physically handicapped.

The discussion which follows is the author's attempt to draw from these early experiences and from her academic background a unified plan for dealing with emotionally disturbed children. The plan reflects the influences of a number of agencies and authors, but in its final form it more closely resembles the program of the Kalamazoo State Hospital than any other agency with which the author has any familiarity. The authors cited as references in the following plan work in the author's special interest area, operant conditioning.
Extensive work in recent years has suggested the value of operant conditioning procedures with children identified as emotionally disturbed (Lovaas, 1965, Ferster, 1965, Baer, 1962, Williams, 1959, Brown and Elliot, 1965, Patterson, 1965, Hington, Sanders, and DeMyer, 1963). Other studies have shown that operant conditioning procedures can be used advantageously in the teaching of basic academic subject matter (Staats and Staats, 1962, Holland, 1960, Moss, 1966, Birnbrauer, Bijou, Wolf, and Kidder, 1965). The studies cited represent the work of psychologists, educators, and specialists in verbal development. The purpose of this paper is to delineate a classroom program for children identified as emotionally disturbed but who do not require in-patient psychiatric care. The program described will be one for children in the intermediate grades since this is the level at which most special education rooms are started in the public schools (Morse, Cutler, and Fink, 1964).

There are a number of assumptions which underlie the educational program presented in this paper. The basic premise is that an educational program can be
beneficial to children identified as being emotionally disturbed. Making this assumption, the curriculum for such children should probably be an intense, carefully planned learning experience rather than a limited or abbreviated version of the regular school program.

It is also assumed that the diagnostic label given to a child is unimportant in planning for the establishment of more desirable behavior. While debate continues between schools of psychological thought over the possible merits of the diagnostic label (Ullmann and Krasner, 1965), the theoretical question need not be of concern to educators planning for the emotionally disturbed. This is because even advocates of psychodiagnosis agree that the dynamics of the disorders they observe are not properly the domain of teachers—even teachers of the emotionally disturbed (Morse, 1958). Therefore it is only reasonable to base the class program upon concepts which can safely be used by teachers.

One branch of psychology does deal with emotional behavior in such a way that non-psychologists can adequately apply its principles. This branch seems to be at least as successful in the treatment of emotional disorders as any of the others (Staats and Staats, 1963). It is generally known as Behaviorism. Behaviorists place considerable emphasis on carefully-controlled experimental evaluations of theoretical concepts (Skinner,
They tend to reject mystical notions about the nature of human behavior in favor of parsimonious, naturalistic views (Staats and Staats, 1963). The basis of the Behaviorist's approach to human behavior is in the study of research data and the derivation of general principles from it (Skinner, 1953). One of the more significant observations and one which is of prime value to teachers is the principle that behavior which is promptly followed by some event that the individual finds rewarding has an increased probability of recurrence (Staats and Staats, 1963). Behaviors controlled by such conditions are called operants (Holland and Skinner, 1961). Rewarding behavior is called reinforcement in Behavioristic literature (Skinner, 1953). Rewards have been shown to be of greater value in controlling behavior than the punishments and threats so frequently used with children in the public schools (Skinner, 1953). Psychologists of this theoretical orientation also advocate the gradual development of desired behavior by successively approximating it (Staats and Staats, 1963). A further principle of this school of psychology is that behavior can be generalized from one environmental situation to another that has some common properties (Staats and Staats, 1963).

These assumptions about the behavior of emotionally disturbed children form the basis of the educational pro-
gram that follows. It will become apparent that the goal of this program lies in improving the childrens' level of functioning to such an extent that they may be promoted out of this program and into a regular school program. At no point should it be assumed that the goal of the program or even the goal for any participant child is simply shelter or escape from overly demanding situations. It is the author's opinion that every aspect of the program for the emotionally disturbed should be designed to enable the children to return and function adequately in the face of such demands at the earliest possible date.
CLASSROOM ARRANGEMENTS

It is probably desirable to locate the classroom for emotionally disturbed children in the same physical plant as classrooms for normal children for several reasons. First, the integration of exceptional children into the regular school program as fully as possible is a principle strongly advocated by educators as being in keeping with the American democratic tradition in education (Jordan, 1962). Secondly, such a location would be more likely to inspire cooperative attitudes in parents who may be fearful of having their children segregated into special programs. Finally, such a location is advantageous to the child in that it creates less of the stigma of being different and presumably makes it possible for him to attend a school nearer his own home.

If classrooms for the emotionally disturbed are to be located in buildings containing classrooms for children enrolled in regular educational programs, conflicts over the use of shared facilities such as gymnasium, auditorium, cafeteria, playground, art room will almost certainly arise. It seems unreasonable to the writer to provide duplicate facilities for separate, concurrent programs for emotionally disturbed and normal children since this would be prohibitive in cost. The granting of
priorities to classrooms for the emotionally disturbed for the use of such facilities would be likely to foster resentment among the other staff members and could prove detrimental to the overall program. Excluding the children enrolled in classes for the emotionally disturbed from the use of such facilities would add to the social stigma of being in such a class as well as to severely limit the program for the special classes. Therefore, it is the author's opinion that such facilities should be shared on the same basis as other classrooms. Of course, all concerned should be flexible enough to make reasonable scheduling changes when circumstances require this.

Much has been written about the optimal size of various kinds of classes for various kinds of children (Haring, 1962). The only reasonable conclusion that can be drawn from this evidence appears to be that optimal class size is largely a matter of opinion. While a 1:1 teacher pupil ratio has its obvious merit in an instructional system, the cost of such a program is prohibitive for virtually all public school systems. The question, then, is one of how small it is possible to make the classes before a point of diminishing returns is reached and any small increments in the rates at which the students learn are offset by the increasingly prohibitive
cost of employing more teachers. The author recommends that class size for the program described should probably not exceed ten. This is not based on research of any formal sort, but on the practical limitations of controlling the behavior of groups of children already identified as emotionally disturbed (Morse, 1958). Each classroom should be staffed with a teacher and a full time assistant.

Existing programs for the emotionally disturbed often provide shorter school days for the enrollees (Morse, Cutler, and Fink, 1964). This has the obvious advantage of often allowing two half day classes to be scheduled in the same room. The present author's approach would be markedly different from this. The school day for children in the classroom for the emotionally disturbed would be the same as that for children in the school’s other intermediate level classrooms. A summer school program would also be provided. The rationale for this is very basic. First, it is assumed that children who are emotionally disturbed are frequently also academically retarded (Morse, Cutler, and Fink, 1964). Secondly, it is assumed that emotional disturbances observed in children are largely a reflection of disorder in their environments (Morse, Cutler, and Fink, 1964). Finally, it is assumed that a school program can enable
students to advance academically and can provide a stable environment for children. Thus it would make little sense to claim that emotionally disturbed children did not have the stamina to face a full school day. On the contrary, the program that has been suggested would, if at all successful, demand less stamina of the child than the unstructured environmental variables outside the classroom. Also, if these children are academically retarded as well as emotionally disturbed, it is reasonable to give them more rather than fewer learning opportunities. The economy factor of being able to schedule two classes for the emotionally disturbed in the same room if half day sessions were used is clearly a false economy when considered on this basis. Of course, experimental adoption of this program would be needed to test the validity of such premises.

The design of the classroom itself would have to be modified somewhat from usual classroom arrangements. This author suggests a classroom very similar to one used by Birnbrauer, Bijou, Wolf, and Kidder (1963). Basically the classroom would look like other classrooms. Individual movable tables and chairs would be provided for each student in the main part of the room. Such tables could then be joined or grouped as desired by the teacher. Along a wall would be located several study
carrels, devices which have shown themselves to be of value when used with emotionally disturbed children (Cruickshank, 1961). At the rear of the room would be at least three small rooms furnished with tables and chairs which could be removed. Both the small study rooms and the main classroom would contain a minimum of windows and breakable fixtures. A lavatory and drinking fountain would adjoin the classroom. The classroom should be carpeted and the walls made as soundproof as possible to reduce extraneous noise and to avoid disturbing other classes.
STUDENTS

The program to be described would be suitable for a variety of children classed as emotionally disturbed. A diagnostic label would not be used as a criterion for determining the admission of any child to the program. The primary basis for the selection of pupils would be that they were exhibiting behavior which prevented their functioning in the regular classroom, but showed sufficient control that in-patient institutional care was not needed. Patients should also be selected on the basis of their parents' willingness to cooperate with the requests of the school. Effectiveness of the total program would be dependent upon the child's generalization of what he had learned in school to the home situation. If the parents were unwilling to cooperate with reasonable school requests, it would certainly be better to admit another child from the waiting list rather than to attempt the probably futile endeavor of training a child carefully for six hours a day, and have any progress undermined during the remaining eighteen (Morse, Cutler, and Fink, 1964).
EDUCATIONAL MATERIALS

Unlike the physical arrangement of the classroom, striking differences between the instructional materials in this room and the traditional classroom could be noted. Clearly absent would be the typical student's desk drawer stacked with textbooks and workbooks for each subject area. Instead of traditional textbooks, programmed materials would be provided (Birnbrauer, Bijou, Wolf, and Kidder, 1963). A good series of reading programs such as the existing McGraw-Hill and McMillan Spectrum series would be basic to the academic course of study. These would be supplemented by programs now being developed in the other subject areas. The teacher herself would program her own presentations so that she was actually presenting very small increments of information when she worked with the children. The blackboard would become a rarely used item as almost no material would ever be presented in a lecture situation. Bulletin boards would be used for interest attracting display charts showing the students' progress in specific areas.

The major advantage of such materials is that they are versatile. A child could work with a program until he completed it, then move on to the next level no matter how rapidly his classmates were working.
Attempts should be made to initiate the program in September with the beginning of the school year and to add new children at times when natural breaks in the school year are recognized. This would serve to give the children a feeling of being a part of a larger educational pattern as well as to establish a tone of stability which is desirable for the children (Redl and Wattenberg, 1959).

Each child's school day should include some time in which he works alone, some time when he works individually with the teacher or teacher's assistant, and some time when he works with other children (Redl and Wattenberg, 1959). It could be presumed that when a child enters the class, he will be most able to work individually with the teacher and least able to work alone. This state of affairs is undesirable because the teacher clearly cannot work individually with all of the children all of the time. The children will also need to learn to work alone and with other children in order to function outside the protected environment of the special classroom. Therefore the teacher's objective should be to build the amount of time that the child can...
effectively use without demanding her unshared presence. This would be done by praising his independent efforts and recording the progress made publicly by using a display chart in the classroom. The process of making the child more independent should be gradual rather than abrupt (Redl and Wattenberg, 1959). Thus the observer would notice a trend of gradually moving from a high frequency of individual help if the class were observed for several months.

Actual control of the children would be based on the assumption that the school environment provides opportunities to gain the attention of other people and to do novel things which are rewarding to the child (Staats and Staats, 1963). It is also assumed that it is more effective to control the kinds of rewards and the antecedent conditions of these rewards for the children rather than to punish children when their behavior becomes objectionable (Skinner, 1953). The three small study rooms described earlier would be useful for this purpose. Such rooms are sometimes known as "time-out" rooms, denoting a period of time out from positive reinforcement. Careful initial planning would determine the minimal behavioral expectations for each child. Whenever the child's behavior fell below these minimal expectations, he would be placed in the time out room.
For example, if a child began to shout, he would be placed in the time-out room until he quieted down and then would be released. Students and teachers alike would be expected to regard this as a therapeutic rather than punitive measure.

Since research has suggested that rewards for good behavior are more effective than punishments for undesirable behavior in the maintenance of long range control, the program provided for these children would make maximum use of rewards and avoid the use of punishment (Skinner, 1953). The teacher would be instructed not to use scoldings, corporal punishment, or public degradation as control techniques. Instead, the positive reinforcing consequences of desirable behavior such as receiving recognition, being granted special play opportunities, and the substantial privilege of being allowed to remain in the classroom would be used to promote desired behavior. Children who did not behave according to the requirements of the situation would simply not receive such rewards. Even very destructive behavior could be effectively controlled in this manner since the child involved would be placed in the time-out room where he would not disturb anyone and could harm neither himself nor anything in his environment. The criterion for acceptable behavior should, of course,
be raised as rapidly as the child seems to adapt to it. Thus, initially minor disturbances in the child's behavior might be overlooked while only the most pressing of behavioral deviations would cause action to be taken. Increasing numbers of the less severe deviations would be dealt with as the gross disturbances came under control.

Some research has been conducted in which food or candy is used to control children's behavior (Staats, Staats, Shultz, and Wolf, 1962). These have generally shown that while such reinforcers may be of value when other types are of limited availability (Lovaas, 1965), they tend to rapidly lose strength since there is a realistic limit to the amount of food or candy a child is desirous of having at any given moment (Skinner, 1953). Thus, social reinforcement such as praise or public recognition would appear to be more useful in a long term training process.

The approach described above is intended to put the control of children's overall behavior in much the same light as the behavior involved in learning arithmetic or reading. That is, the social behavior deficits which cause children to be labeled emotionally disturbed can be considered learning deficits (Staats and Staats, 1963). The children, then, can be taught
more adequate kinds of behavior by the same processes shown to be effective in teaching classroom subjects. No punitive attitudes need be displayed and no assumptions about psychodynamic causes need be made.

Another significant aspect of the total program of control would be a spirit of preventive discipline. The techniques previously described would presumably have the effect of preventing many of the discipline problems ordinarily observed in emotionally disturbed children. If it is assumed that emotionally disturbed behavior is produced in situations in which the child cannot cope with the demands placed upon him (Jordan, 1962), a situation which meets the child at his own level of behavior and increases in complexity only as the child learns to handle more complex problems could be expected to show fewer behavior problems.

The advantage to having the available study rooms and study carrels would lie in making it possible for the child to segregate himself if he became concerned about his own inability to control himself in a given situation. There are many values that may be derived from allowing the child to use the private work areas at his own discretion. First, it establishes the child's right to a certain amount of privacy. It would also serve to reduce behavior problems since one would expect that the child himself is aware of periods when
he is easily distracted or when he wants to create some kind of disturbance. The opportunity for the child himself to determine when he will use the study rooms also serves to clearly establish that the use of such rooms is therapeutic rather than disciplinary.

It has already been established that psychiatric diagnostic classifications would not be useful in this program for emotionally disturbed children. Therefore, psychological testing and interviews would not be done. If such records had been made prior to a child's admission to the program, they would not be made available to persons working with the child. It has been established that such information is not necessary in this approach and its presence could only serve to prejudice the teacher's viewpoint. If the school district required periodic intelligence testing, the results of those tests should also not be made available to those working directly with the child. Like the other psychological tests mentioned, they could only interfere with the educative process. Unlike the psychological tests, standard achievement batteries would have a place in the program. They would provide a sound basis for reporting academic progress to parents as well as feedback to the teacher as to whether her students were getting instruction in the subject areas that would be expected of them when they re-entered regular classes.
While testing would be de-emphasized, careful record keeping would be strongly emphasized. As each child entered the program, a careful tabulation of undesirable behaviors which the child demonstrated and important behaviors should show but did not should be made by all those working with him. Such behaviors should be clearly specified as observable phenomena (i.e. stating that a child frequently kicks other boys in the class rather than saying that he is aggressive.) (Staats and Staats, 1963) The teacher and her assistant should record accurately the frequency of all behaviors of concern when the child enters the class. Periodic rechecks as to the frequency of these behaviors should then be made. The criterion of improvement would thus be defined as a reduction or elimination of undesirable behaviors or an appearance or increase of desired behaviors. This method should enable the teacher to make a rapid, accurate appraisal of whether the child has improved and to what degree.
SUMMARY

An approach to special educational programming for emotionally disturbed children in the intermediate grades has been proposed. The program has been founded on learning concepts. Some principles of learning experimentally derived by psychologists have been used to describe a program that would provide social as well as academic training to the students involved. Many of the components of the program described in this paper have been used on an experimental basis. Since the value of the total program could only be assessed by experimental adoption, it is hoped that such research will be done. It is also hoped that data obtained from such studies and from research in other teaching methods will represent a cooperative effort in the area of research methodology so that there may be some means of comparing the effectiveness of programs studied in different experiments.
REFERENCES


